



Religious Hospitallers  
of Saint Joseph  
of the Hotel Dieu of Kingston  
HOTEL DIEU HOSPITAL

## Colorectal Screening Referral

Telephone: 613-544-3400 Ext. 2453  
[www.hoteldieu.com](http://www.hoteldieu.com)

Name \_\_\_\_\_  
Date of birth (yyyy/mm/dd) \_\_\_\_\_  
Health Card # \_\_\_\_\_ Version \_\_\_\_\_  
Phone # Home \_\_\_\_\_  
Work \_\_\_\_\_  
Alternate \_\_\_\_\_  
Address \_\_\_\_\_

### Indication for Referral - patient must be asymptomatic and meet the following criteria

- Patient (50 years of age or older) referred after a positive fecal occult blood test (FOBT) - **please attach results**  
 Patient referred because one or more first degree relative, (*parent, sibling, child*), had colorectal cancer

*Note: Age of referral recommended at age 50 years or ten years earlier than relative's diagnosis, whichever comes first*

### Medical History - check appropriate box(s)

Height: \_\_\_\_\_ m Weight: \_\_\_\_\_ kg

Adverse reactions:  No  Yes, if yes list: \_\_\_\_\_

Anticoagulation/coagulation disorder - *specify*: \_\_\_\_\_

Patient using non-steroidal anti-inflammatory drugs (NSAIDS)/platelet inhibitor medication -  No  Yes

If yes list: \_\_\_\_\_

Diabetes Mellitus on medication  Oral hypoglycemic  Insulin - *specify* \_\_\_\_\_

Emphysema/other severe pulmonary disease - *specify*: \_\_\_\_\_

Pacemaker/implantable cardiac defibrillator (ICD) - *specify*: \_\_\_\_\_

Heart Disease:  valvular  coronary artery

Uncontrolled hypertension - *most recent blood pressure* \_\_\_\_\_ Date (yyyy/mm/dd) \_\_\_\_\_

Abnormal renal function - *most recent serum creatinine level*: \_\_\_\_\_ mcmol Date (yyyy/mm/dd) \_\_\_\_\_

**No comorbid condition(s)**

Medications (*list*): \_\_\_\_\_

Other: \_\_\_\_\_

### Referring Practitioner Information

Practitioner Printed Name: \_\_\_\_\_ Practitioner Signature: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Patient notified of referral:  No  Yes

Date of Referral: \_\_\_\_\_ *If yes indicate date:* \_\_\_\_\_  
yyyy/mm/dd yyyy/mm/dd

### FAX TO ENDOSCOPY UNIT - 613-544-5718

**Please advise patients:** - they will be contacted by the Hospital with the appointment date & time  
- to bring their health card to the appointment.

**Hospital use only:**  Clinic appointment required  Direct to colonoscopy